Section 3

Program Design

Section 3. Program Design

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

Answer by completing the following.

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Table 3.1.1

STATE-DESIGNED SCHIP PROGRAM	
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	Statewide
Age	KidsCare is available to children under 19 years of age. A child reaches age 19 the day before the anniversary of the date of birth. Coverage will continue through the month in which the child turns age 19.
Income (define countable income)	The combined gross income of the family household member may not exceed 150 percent of the FPL for state fiscal year 1999, and 200 percent for state fiscal year 2000 through 2007.
Resources (including any standards relating to spend downs and disposition of resources)	KidsCare does not have a resource test.
Residency requirements	Arizona residency is required. An Arizona resident is a person who currently lives in Arizona and intends to remain in the state indefinitely.
Disability status	N/A
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	A child will not be eligible for KidsCare if the child is: • Eligible for Medicaid, • Covered under an employer's group health insurance plan, • Covered through family or individual health care coverage, • Eligible for health benefits coverage under a state health benefits plan on the basis of a family member's employment with a public agency, or • Covered by health insurance during previous six months unless that health insurance was discontinued due to the involuntary loss of employment.
Other standards (identify and describe)	N/A

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	**Medicaid SCHIP Expansion Program**	**State-designed SCHIP Program**	**Other SCHIP Program*** _____
Monthly			
Every six months			
Every twelve months		For KidsCare Applications	
Other (specify)			

* Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

_x_ Yes Which program(s)? KidsCare
For how long? Initial 12-month guaranteed period*
___ No

* A child who has been determined eligible for KidsCare will be guaranteed an initial 12 months of continuous coverage unless the child:

- Attains the age of 19,
- Is no longer a resident of the state,
- Is an inmate of a public institution,
- Is enrolled in Medicaid,
- Is determined to have been ineligible at time of approval,
- Obtains private or group health insurance, or
- Is adopted and no longer qualifies for KidsCare.

3.1.4 Does the SCHIP program provide retroactive eligibility?

___ Yes Which program(s)? _____
How many months look-back? _____
_x_ No

3.1.5 Does the SCHIP program have presumptive eligibility?

___ Yes Which program(s)?
Which populations?
Who determines?

_x_ No

3.1.6 Do your Medicaid program and SCHIP program have a joint application?

___Yes Is the joint application used to determine eligibility for other State programs?
If yes, specify. (see below)

_x_ No

However, AHCCCS does use a newly developed and simplified two-page joint application for KidsCare and Medicaid eligibility determinations. Each KidsCare application is screened for Medicaid eligibility. Applicants may mail-in the applications. AHCCCS is considering a universal application, which would be used to determine eligibility for other state programs as well as KidsCare and Medicaid.

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

Strengths in Increasing Creditable Health Coverage:

- As noted above, AHCCCS has developed a simplified two-page application, which can be used as a dual eligibility determination for both KidsCare and Medicaid. Recognizing Arizona's diversity, applications are in both Spanish and English, while interpreter services are available upon request. The eligibility process has been streamlined by eliminating the office visit, and an applicant may call a toll free number 24 hours a day, 7 days-a-week for assistance.

- The AHCCCS Administration has been able to streamline its operations by sharing co-located staff of KidsCare and DES for eligibility determinations and re-determinations for KidsCare and Medicaid. Administrative costs for the staff are also split between the programs. KidsCare and DES screen applicants for eligibility in other AHCCCS programs to make the process more seamless to the applicant. The Division of Member Services at AHCCCS is working on a universal application that will include Medicaid, KidsCare and other programs that offer health care services.

- If a child is found to be ineligible for Title XIX due to excess income or resources, DES refers the discontinued or denied application to AHCCCS for a KidsCare eligibility determination. AHCCCS and DES are also screening and taking applications for juveniles prior to their release from correctional facilities. This is to ensure that KidsCare or Title XIX will cover them immediately upon release so they have access to medical, behavioral health, substance abuse services and prescriptions.

Some Difficulties in Increasing Creditable Health Coverage:

- The 10 percent administrative cap on expenditures hampers states in their outreach efforts and fiscal flexibility.

- Current practice does not allow families a choice between enrolling in KidsCare instead of Medicaid. Some families, who have found they are eligible for Medicaid instead of KidsCare, have deferred coverage because they did not want to participate in the Medicaid program.

- The AHCCCS Administration has found it difficult to consider alternative avenues to increase creditable coverage, such as employer-sponsored or family-based equivalence, because of the administrative burdens which include difficulties with: benchmark equivalence, wrap-around coverage, cost effectiveness standard, employer contributions of 60 percent, and cost-sharing measures. These impediments could be greatly reduced if HCFA allowed greater state flexibility and creative innovation.

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

Since no redeterminations are due until November 1, 1999, analysis of the strengths and weaknesses of this process is not available for this reporting period. AHCCCS will redetermine eligibility annually based on the same criteria which is used in the initial determination of eligibility. Continuing eligibility after the initial 12-month guaranteed period would be for a 12-month period unless the member no longer meets the KidsCare eligibility criteria. If AHCCCS determines that the child no longer meets the eligibility criteria, or the child, parent or legal guardian fails to respond or cooperate with the redetermination of eligibility, coverage will be terminated.

In the redetermination process, AHCCCS sends a reminder letter to the child, parent or legal guardian about the impending redetermination. The redetermination is mailed to the family, and the family only has to indicate any changes from the previous determination and attach income verification. In addition, follow-up phone calls will be made to those households who do not respond to the reminder letters.

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

Answered by completing the following.

3.2.1 Benefits

Please complete Table 3.2.1 for each of your SCHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

Table 3.2.1 SCHIP Program Type: State-designed SCHIP Program			
Benefit	**Is Service Covered? (√ = yes)**	**Cost-Sharing (Specify)**	**Benefit Limits (Specify)**
Inpatient hospital services	√		Inpatient hospital services, including medically necessary ancillary services, and emergency hospital services, if furnished by a licensed hospital and provided by or under the direction of a PCP or primary care practitioner according to federal and state law, rules, and AHCCCS Policies and Procedures. Inpatient hospital services include services provided in an institution specializing in the care and treatment of members with mental diseases. Medically necessary transplant services, which are not experimental, if provided to correct or ameliorate disabilities, physical illnesses or conditions. Transplantation services will be authorized in accordance with AHCCCS transplantation policies.
Emergency hospital services	√	$5 for non-emergency use of an emergency room.	
Outpatient hospital services	√		Outpatient hospital services ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. Outpatient hospital services include services provided by or under the direction of a PCP or primary care practitioner or licensed behavioral health professional according to federal and state law.
Physician services	√		Physician services if provided by or under the direction of a PCP, psychiatrist, or under the direction of a primary care practitioner according to federal and state law. Services are covered whether furnished in the office, the member's home, a hospital, a nursing home or other setting. Only psychiatrists, psychologists, psychiatric nurse practitioners may bill independently for behavioral health services. Other behavioral health professionals and behavioral health technicians shall be affiliated with a qualified agency, and services provided by these individuals shall be billed through that agency.
Clinic services	√		
Prescription drugs	√		

Table 3.2.1 SCHIP Program Type: State-designed SCHIP Program			
Benefit	**Is Service Covered? (√ = yes)**	**Cost-Sharing (Specify)**	**Benefit Limits (Specify)**
Over-the-counter medications	√		A nonprescription medication is covered if an appropriate alternative over the counter medication is available and less costly than a prescription medication.
Outpatient laboratory and radiology services	√		
Prenatal care	√		
Family planning services	√		a. The following family planning services are provided: • Contraceptive counseling, medication, supplies and associated medical and laboratory exams. • Natural family planning education or referral. b. Infertility services and reversal of surgically induced infertility are not covered services. c. Family planning services do not include abortion or abortion counseling.
Inpatient mental health services	√		a. Inpatient behavioral health services are limited to 30 days of inpatient care per contract year. b. Applicants in an Institute for Mental Disease at the time of application are excluded from enrollment in KidsCare. c. Inpatient substance abuse treatment services count towards 30-day limit in 12-month period.
Outpatient mental health services	√		a. All outpatient behavioral health services are limited to 30 visits per contract year. b. Substance abuse outpatient services count towards the 30-day. c. Outpatient behavioral health services, other than substance abuse treatment services.
Inpatient substance abuse treatment services	√		a. Inpatient substance abuse treatment is limited to acute detoxification. b. Inpatient mental health treatment counts toward 30-day limit in a contract year.

Table 3.2.1 SCHIP Program Type: State-designed SCHIP Program			
Benefit	**Is Service Covered? (√ = yes)**	**Cost-Sharing (Specify)**	**Benefit Limits (Specify)**
Residential substance abuse treatment services	√		a. Inpatient substance abuse treatment is limited to acute detoxification. b. Inpatient mental health treatment counts toward 30-day limit in a contract year.
Outpatient substance abuse treatment services	√		a. Rehabilitation services provided by a substance abuse rehabilitation agency that does not exceed 30 outpatient visits for each contract year. b. Mental health outpatient services count towards the 30-day limit in a contract year.
Durable medical equipment	√		
Disposable medical supplies	√		Disposable medical supplies include consumable items covered under Medicare that are not reusable.
Preventive dental services	√		a. Dental services, including routine, preventive, therapeutic and emergency services. b. Dentures and dental devices are covered if authorized in consultation with a dentist.
Restorative dental services	√		
Hearing screening	√		
Hearing aids	√		
Vision screening	√		Eye examinations for prescriptive lenses limited to one visit per year.
Corrective lenses (including eyeglasses)	√		Eyeglasses are limited to one pair per contract year.
Developmental assessment	√		
Immunizations	√		
Well-baby visits	√		
Well-child visits	√		

Table 3.2.1 SCHIP Program Type: State-designed SCHIP Program			
Benefit	**Is Service Covered? (√ = yes)**	**Cost-Sharing (Specify)**	**Benefit Limits (Specify)**
Physical therapy	√		
Speech therapy	√		
Occupational therapy	√		
Physical rehabilitation services	√		
Podiatric services	√		
Chiropractic services	√		
Medical transportation	√		Emergency ambulance transportation if a medically necessary emergency exists. Non-emergency medically necessary transportation is not covered.
Home health services	√		
Nursing facility	√		Nursing facility services for a maximum of 90 days when the medical condition of the person indicates that nursing facility services are necessary to prevent hospitalization.
ICF/MR			
Hospice care	√		Hospice services for a terminally ill member.
Private duty nursing	√		a. Private duty nursing care, respiratory care services, and services provided by certified nurse practitioners in a home or other setting. b. Certified nurse midwife services when they are rendered in collaboration with a licensed physician or PCP or primary care practitioner in accordance with AHCCCS Policies and Procedures.
Personal care services	√		
Habilitative services	√		Services provided in a facility, home, or other setting if recognized by state law.
Case management/Care coordination	√		Care coordination will be available through contractors, primary care providers and behavioral health providers.

Table 3.2.1 SCHIP Program Type: State-designed SCHIP Program			
Benefit	**Is Service Covered? (√ = yes)**	**Cost-Sharing (Specify)**	**Benefit Limits (Specify)**
Non-emergency transportation			
Interpreter services	√		
Other (Specify)			
Other (Specify)			
Other (Specify)			

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to SCHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

The scope and range of KidsCare health coverage is detailed in Chart 3.2.1. KidsCare does not impose any cost sharing measures except for a $5 charge per non-emergency use of an emergency room use during this reporting period.

Meeting the Needs of Children with Special Needs

Meeting the needs of children with special needs is important to the AHCCCS Administration. Preventive services are an integral part of the service package. Children with special health care needs have access to medical, diagnostic, screenings, preventive, restorative, remedial, therapeutic, or rehabilitative services whether provided in a facility, home, or other setting if recognized by state law. In addition, children with special needs have access to respiratory therapy and are entitled to eye examinations for prescriptive lenses one time a year. AHCCCS also ensures that immunizations, preventive health services, patient education, age and gender appropriate clinical screening tests and health exams are part of the service package.

Reaching beyond AHCCCS, KidsCare works closely with other programs, such as Children's Rehabilitative Services, which offer a range of services for children with special needs. AHCCCS also coordinates outreach services with providers, who specialize in working with children with special needs (Please see Questions 3.4 to 3.4.5 for more information on outreach).

Enabling Services

AHCCCS not only provides preventive health care services to its members, it also takes a proactive stance in offering enabling services. AHCCCS has met with many tribal entities to discuss ways to enhance the KidsCare Program and its outreach strategies. These meetings have included:

- Area IHS agencies,
- Arizona Inter-tribal Council, which represents 20 of Arizona's 21 Indian Tribes,
- Navajo Nation,
- Urban Indian Centers, and
- Indian Health Advisory Committee.

To spearhead these efforts, AHCCCS has a Native American Coordinator who provides a

link between AHCCCS and the tribes. The Coordinator provides opportunities for both communication and education. Outreach efforts can be seen at Native American events, within newspapers, and on radio. In addition, KidsCare reaches out to IHS and participating tribal facilities that provide KidsCare services by offering training on how to complete KidsCare applications. Native American children have a choice of either enrolling in IHS or a contractor in their geographic service area. Applications and enrollment information are also available at IHS and tribal locations.

Finally in recognizing the diversity within Arizona, all printed materials are in English and Spanish, and interpreter services are available upon request through the health plans.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3

Type of delivery system	**Medicaid SCHIP Expansion Program**	**State-designed SCHIP Program**	**Other SCHIP Program***
A. Comprehensive risk managed care organizations (MCOs)		Yes	
Statewide?	___ Yes ___ No	_X_ Yes ___ No	___ Yes ___ No
Mandatory enrollment?	___ Yes ___ No	_X_ Yes ___ No	___ Yes ___ No
Number of MCOs		12	
B. Primary care case management (PCCM) program		N/A	
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)		Behavioral Health services are carved out.	
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)		Native Americans can enroll in Fee-for-Service through IHS.	
E. Other (specify)		N/A	
F. Other (specify)		N/A	
G. Other (specify)		N/A	

3.3 How much does SCHIP cost families?

At this time, KidsCare only assesses a copayment of $5 for each non-emergency use of the emergency room. No other premiums, deductibles, or enrollment fees have been applied during this reporting period. AHCCCS is monitoring the efforts of other states in this area as well as gathering feedback from external stakeholders because premiums will be implemented on October 1, 1999 for those between 150 percent to 200 percent FPL.

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/copayments, or other out-of-pocket expenses paid by the family.)

___ No, skip to section 3.4

_x_ Yes, check all that apply in Table 3.3.1

Table 3.3.1

Type of cost-sharing	Medicaid SCHIP Expansion Program	State-designed SCHIP Program	Other SCHIP Program*
Premiums		N/A	
Enrollment fee		N/A	
Deductibles		N/A	
Coinsurance/copayments **		$5 per non-emergency use of the emergency room	
Other (specify) _____		N/A	

* Make a separate column for each "other" program identified in section 2.1.1. To add column to a table, right click on the mouse, select "insert" and choose "column".

** See Table 3.2.1 for detailed information.

3.3.2 If premiums are charged: What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

N/A. At this time, KidsCare does not assess premiums.

3.3.3 If premiums are charged: Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

N/A. At this time, KidsCare does not assess premiums. (See 3.3)

___ Employer
___ Family
___ Absent parent
___ Private donations/sponsorship
___ Other (specify) _____

3.3.4 If enrollment fee is charged: What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

N/A. At this time, KidsCare does not assess an enrollment fee.

3.3.5 If deductibles are charged: What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

N/A. At this time, KidsCare does not assess deductibles.

3.3.6 How are families notified of their cost-sharing requirements under SCHIP, including the 5 percent cap?

Information about cost-sharing is included in the outreach and application materials. In addition, information can be found in Member handbooks provided by KidsCare contractors, the *Arizona Administrative Register,* and other rulemaking activities conducted by the AHCCCS Administration. Finally, AHCCCS is making a concerted effort to communicate through Native American newsletters and meetings that Native Americans are exempt from paying any cost sharing.

3.3.7 How is your SCHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

_x_ Shoebox method (families save records documenting cumulative level of cost sharing)
___ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
___ Other (specify)_____

Based on KidsCare's nominal cost-sharing measures, the cost-sharing cap is not an issue during this reporting period. However, families are advised that the total cost-sharing under KidsCare cannot exceed five percent of the families' income; therefore, AHCCCS will advise any family to cease paying the copayment when the percentage limit has been exceeded. Since AHCCCS only assesses a five dollar copayment on non-emergency use of the emergency room, a child in a family of two at 150 percent FPL would have to

make 162 non-emergency visits to the emergency room in a one year period. Families with higher incomes would have to make even more visits.

3.3.8 What percent of families hit the 5 percent cap since your SCHIP program was implemented? (If more than one SCHIP program with cost sharing, specify for each program.)

No families have reached the 5 percent cap since the implementation of KidsCare because of the unlikelihood of exceeding the 5 percent income limit as a result of visiting the emergency room for a non-emergency use. A child in a family of two at 150 percent FPL would have to the visit the emergency room 162 times in a year to meet the limit.

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

The AHCCCS Administration does not assess premiums. Because the cost-sharing copayment measures are nominal and not mandatory, impact on participation is not an issue.

3.4 How do you reach and inform potential enrollees?

Answer by completing the following sections.

Outreach Strategies

KidsCare has combined a grassroots effort with a major media campaign through a marketing firm, Riester-Robb, to enroll children into KidsCare. In addition to simplifying the application and verification process, Arizona developed an extensive outreach program that informs families about KidsCare.

At implementation, the KidsCare Administration had the following strategies:

- Identifying, and providing direct mailing to, over 70,000 households who had previously applied for the following programs and were believed to have income below 150 percent of FPL. These programs were:
  - Title XIX (Ribicoff and S.O.B.R.A., which is the Sixth Omnibus Reconciliation Act);
  - WIC (Women, Infants and Children Nutritional Program);
  - CRS;
  - DES Division of Developmental Disabilities;
  - Food Stamps;
  - ADHS (Arizona Department of Health Services) state funded behavioral health,
  - DES child care services;
- Providing direct mailing to 30,000 recent recipients of Unemployment Insurance to inform them of the program;

- Coordinating an interface between DES and AHCCCS to refer applicants denied or discontinued from Title XIX due to excess household income and resources to KidsCare. This referral process from DES to AHCCCS includes children currently receiving Title XIX who are discontinued or denied due to income or resources, but whose household income is equal or less than 150 percent of FPL. Discontinued Title XIX cases are automatically posted as KidsCare eligible;
- Providing information, materials and training to safety net providers, community groups, hospitals, health departments and human service agencies;
- Providing information, materials and training to Native American tribes and working with them to decide what outreach would work best for them;
- Having the Governor initiate the program with a "KidsCare Month";
- Distributing information to schools and community agencies when requested to do so, and assist in educating school staff about the program; and
- Identifying opportunities for media exposure for the program.

Highlights of the KidsCare Outreach Campaign

KidsCare has been able to capitalize on many opportunities over the past year, especially those opportunities presented by members of the community who have helped KidsCare with its outreach efforts. Highlights over the past year include:

- Sponsorships by major corporations and companies such as:
  - Osco Drugs,
  - Bashas,
  - Hickman's Eggs,
  - Video Update,
  - Domino's Pizza,
  - Diamondbacks, and
  - Arizona Thunder;
- Innovative marketing such as KidsCare logos on neighborhood ice cream push carts (paletas) in Hispanic neighborhoods;
- Contributions from the Children's Action Alliance, which is a Robert Wood Johnson grantee for KidsCare Outreach, called *Covering Kids.* Three grants were awarded by the Children's Action Alliance;
- Contributions from St. Luke's Charitable Health Trust which awarded seven grants to community organizations to conduct outreach programs as part of its *Kids Connect* program;
- Contributions from Arizona Farmworkers Coalition, which underwrote the printing of special editions of their newsletter with articles about KidsCare. KidsCare has also had Public Service Announcements (PSAs) on Radio Campesina;
- KidsCare-avan – a traveling van with bi-lingual staff featuring a party bouncer and incentive items for children and information and applications for parents. Used for promotions, sign-up drives, and statewide media tours, particularly to small towns in rural areas. Osco Drugs underwrote rental and maintenance costs for the van;
- Contributions from Flinn Foundation, which funded several activities, including over

$100,000 in various grants commissioning studies on the KidsCare program. More recently, the Flinn Foundation has continued its support by funding several grants for KidsCare outreach efforts;

- Direct mailings to over 115,000 households with members who are likely eligible for KidsCare;
- Design/distribution of over 650,000 applications, brochures, posters, and flyers and over 6,000 training packets free of charge to requesters. All materials are in English and Spanish;
- Fifty-five training sessions held statewide for over agencies, community groups, non-profits, and school districts to help increase awareness of KidsCare and assist with applications;
- Informational presentations statewide to over 160 groups such as hospitals, immunization coordinators, maternal/child health staff, WIC and Headstart staff, Inter-Tribal Council, etc;
- Contact with and training of representatives of a majority of the 21 tribes in Arizona;
- Presentations and trainings to 15 school districts and county school superintendents;
- Mailing 800,000 flyers to school children statewide and mailed letters and flyers to 1,200 administrators of free and reduced lunch programs;
- Media and marketing campaign based on concept of social marketing to change people's perceptions and behavior regarding health insurance;
- Design of KidsCare logo and slogan to "brand" the program and create entertaining way to get message across;
- Development of a one-page quarterly newsletter "What's New With KidsCare" distributed to all source codes alerting communities of changes in the program;
- Development of entertaining TV and radio ads in English and Spanish; and paid TV and radio November, 1998 and June, July and 2 weeks in August,1999; and
- Significant media coverage of campaign, especially radio and newsprint.

Coordinating Outreach Efforts

Before capitalizing on the contributions of many community organizations and the media coverage, it was important to focus on KidsCare outreach efforts and coordination. With that in mind, Riester-Robb, the contracted marketing firm, conducted consumer research focused on what potential consumers knew and thought of health insurance, their familiarity with the KidsCare name and other relevant questions. Six focus groups for adults and teens were held and a phone survey was conducted of 400 households statewide.

Results of this research showed that health care and health insurance were not "top" issues for most people at this income level, particularly if their own children were not sick. If respondents did need to see a doctor, they tended to pay in cash or by a payment plan. Therefore, AHCCCS knew that it would need to establish a strong connection through a social marketing campaign between peoples' personal lives and what health insurance could do for them.

The media message that was designed focused on "Because kids will be kids" (e.g. broken bones, fevers, accidents), don't wait until something happens, get health insurance now. This slogan was used in TV and radio ads in a funny and entertaining manner while stressing that KidsCare is free or low-cost health insurance for children of working families. One goal was to counter a concern about welfare stigma.

To get the message out, AHCCCS developed the KidsCare Outreach Task Force, which was comprised of a variety of statewide organizations and agencies to facilitate communication and coordination between outreach efforts underway. The Outreach Coordinator orchestrated efforts with a wide variety of organizations, agencies, volunteer groups and programs to ensure that the community at large was aware of the program, that efforts were not duplicative, and that resources were available to assist potential applicants in filling out applications.

3.4.1 What client education and outreach approaches does your SCHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your SCHIP program(s). Specify which approaches are used (√=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1

Approach	Medicaid SCHIP Expansion		State-Designed SCHIP Program		Comments
	√ = Yes	Rating (1-5)	√ = Yes	Rating (1-5)	
Billboards			√	2	
Brochures/flyers			√	4	
Direct mail by State/enrollment broker/administrative contractor			√	2	
Education sessions			√	4	
Home visits by State/enrollment broker/administrative contractor			√	5	Home Visits also by "promotores" or community health workers
Hotline			√	5	
Incentives for education/outreach staff					
Incentives for enrollees			√	5	Please see KidsCare-avan on page 36 under "other".
Incentives for insurance agents					
Non-traditional hours for application intake					
Prime-time TV advertisements			√	3	
Public access cable TV					
Public transportation ads					
Radio/newspaper/TV advertisement and PSAs			√	5	
Signs/posters			√	4	Also, point-of-purchase displays
State/broker initiated phone calls					

Table 3.4.1

Approach	Medicaid SCHIP Expansion		State-Designed SCHIP Program		Comments
	√ = Yes	Rating (1-5)	√ = Yes	Rating (1-5)	
Other (specify)			√	5	KidsCare-avan – a traveling van with bi-lingual staff featuring a party bouncer that provides incentive items for children and information and applications for parents. KidsCare-avan used for promotions, sign-ups and statewide media tours, particularly to small towns in rural areas.
Other (specify)			√	4	AHCCCS provides outreach and training to IHS benefit coordinators.
Other (specify)			√	5	Community outreach support to enhance Native American enrollment, including collaboration among the Phoenix Children's Hospital, Native American community, Health Center, Inc., and St. Luke's Charitable Health Trust.
Other (specify)			√	5	Referral by social service agencies and community organizations.
Other (specify)			√	5	Innovative marketing such as KidsCare logo and brochures on ice cream push carts in Hispanic neighborhoods.

3.4.2 Where does your SCHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your SCHIP program(s) for client education and outreach. Specify which settings are used (√=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2

Setting	Medicaid SCHIP Expansion		State-Designed SCHIP Program		Other SCHIP Program*	
	√ = Yes	Rating (1-5)	√ = Yes	Rating (1-5)	√ = Yes	Rating (1-5)
Battered women shelters			√	2		
Community sponsored events			√	4		
Beneficiary's home			√	5		
Day care centers			√	3		
Faith communities			√	4		
Fast food restaurants			√	3		
Grocery stores			√	3		
Homeless shelters			√	2		
Job training centers			√	3		
Laundromats						
Libraries						
Local/community health centers			√	5		
Point of service/provider locations			√	4		
Public meetings/health fairs			√	4		
Public housing						
Schools/adult education sites			√	5		
Senior centers						
Social service agency			√	5		

Table 3.4.2						
Setting	**Medicaid SCHIP Expansion**		**State-Designed SCHIP Program**		**Other SCHIP Program***	
	√ = Yes	**Rating (1-5)**	**√ = Yes**	**Rating (1-5)**	**√ = Yes**	**Rating (1-5)**
Workplace						
Other (specify)						
Other (specify)						

* Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

Evaluation of Effectiveness

Methods for evaluating the success of various outreach components of the program were designed before the program was implemented and are accomplished through four primary means:

- Source of applications being received;
- Numbers of applications received;
- Tracking where applicants heard about the program; and
- Tracking sources and numbers of phone calls to the KidsCare Hotline number.

When KidsCare applications are requested by agencies, community groups, etc., the requester is assigned a specific source code number. When applications are received in the KidsCare Unit, it is possible for AHCCCS to identify where the applicant received the application from the source code. These numbers are tracked on a monthly cumulative basis based on close to 350 source codes that include schools and school districts, state agencies, hospitals, libraries, non-profit organizations, clinics, physician offices, tribal entities, and a host of other locations. In total, AHCCCS tracked over 43,000 applications by source codes.

When applicants are filling out the application, they are asked to check a box(es) on the cover of the application indicating where they heard about the program. For example, they are asked to check whether they heard about KidsCare through a notice in the mail, from a doctor's office or health center, from TV, from a Community Health worker, etc. These results are tabulated and tracked on a monthly basis (see Attachment A).

The number of applications received by the KidsCare Unit is tracked on a monthly basis (see Attachment B).

The number of calls to the KidsCare Hotline is tracked on a monthly basis and callers are asked where they heard about the program (see Attachment C).

In September 1999, KidsCare, through its advertising agency Riester-Robb, conducted a follow-up telephone survey of Arizona parents to provide comparative data to the initial focus groups and telephone survey done in February at the start of the advertising and media campaign. The study looked at current health insurance coverage for lower income families as well as level of awareness of KidsCare and its advertising campaign. Results showed that approximately 59 percent of targeted parents indicated they heard about KidsCare, up from 39 percent when the campaign began. A summary of the results can be found in Attachment D.

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

- All outreach materials and applications are printed in both English and Spanish. All television and radio ads have been produced in English and Spanish and a majority of the paid radio air time has been focused toward the Hispanic market in major metropolitan areas. Of the calls received, a significant number heard of the program through radio ads, particularly Hispanic radio. In addition, the AHCCCS Public Information Office did monthly radio interviews on a Hispanic radio station in Tucson. We have worked closely with the Arizona Farmworkers Coalition in underwriting the printing and mailing of special editions of their newsletter with articles about KidsCare, and have run PSAs on Radio Campesina. In Hispanic communities, particularly in southern Arizona border communities, the use of "Promotores" or lay health workers who are members of the local community has been very successful for hard to reach populations. Promoteres visit families in their homes, give them health information and referrals, and assist with applications. AHCCCS has also done some creative marketing targeting Hispanics, such as training of vendors and the use of the KidsCare logo on the side of "Paletas". Paletas are ice cream pushcarts which vendors push around neighborhoods during the summer. This particular effort received considerable newspaper and television coverage.

- AHCCCS' Native American Coordinator had contact with and trained representatives of a majority of the 21 tribes and Navajo Nation in Arizona regarding KidsCare. In addition, the coordinator has met with tribal councils and health departments of many of the major tribes, who provide outreach efforts to their members. AHCCCS also works closely with IHS and IHS Headstart programs. Several organizations which have received grants for outreach are focusing their efforts on Native Americans, both urban and on reservation, and their efforts include radio ads translated into Navajo, colorful brochures with Native American symbols and visits to chapter houses with applications and portable copying machines.

- A full page color ad and article will be appearing in the next edition of the "Arizona's Black Pages" (much like the Yellow Pages) and news articles and ads have been placed in publications such as the Arizona Informant, an African-American

publication.

- Another very successful way of reaching "hard-to-reach" populations has been through the use of the KidsCare-avan. The van and its staff have provided mobility for the program and have been very successful in interacting with the media – usually radio and newspapers – in small towns and rural areas. In addition, the van has appeared at events on reservation where it would have been very difficult to send volunteers.

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

Arizona is a large state with diverse populations and regions. As of October 1, 1999, Hispanics represented 54 percent of all children approved for KidsCare. The rest includes: Caucasians representing 31 percent, Native Americans representing 9 percent, African Americans representing 4 percent, and Asian/Pacific Islanders representing 1 percent of total children enrolled in KidsCare. In addition, Arizona is represented by large tracks of rural area and one of the fastest growing counties in the country – Maricopa County – with metropolitan Phoenix spurring much of this growth. In light of this, the KidsCare program has attempted to meet different outreach needs.

Since Hispanics represented the largest portion of KidsCare enrollment, it was important to effectively reach eligible children and their parents within this community. Radio has been a very effective way of reaching the Hispanic population. For example, KidsCare has used Public Service Announcements (PSAs) on Radio Campesina. Another useful method has been Promotores in smaller, rural communities who visit families door-to-door. However, the use of Promotores in larger urban communities such as Tucson has not worked as well since these community health workers may not be known in the local community or neighborhood. One-on-one assistance with the application and follow-up with individual families also works best in rural areas. Community coalitions and community agencies receiving outreach grants have been more effective not only in generating numbers of applications, but also in submitting more complete applications. Finally, the Arizona Farmworkers Coalition has underwritten the printing of special editions of their newsletter with articles about KidsCare.

Reaching tribal communities has also been a part of outreach efforts. Tribes have integrated their outreach efforts into community events such as the Navajo Nation Fair and the Salt River Pima Maricopa Indian Community Child Health Fair. In addition, other mediums have been used for outreach purposes such as the newsletters A*HCCCS Road* and the *KidsCare News*, or the television program *21st Century*, which all serve Native American communities. Finally, the KidsCare-avan has made several stops as part of its Native American outreach efforts, perhaps having the most impact among all these endeavors.

In reaching out to African Americans, a full page color ad and article is in "Arizona's

Black Pages" (much like the Yellow Pages). In addition, news articles and ads have been placed in publications such as the Arizona Informant, an African American publication.

Finally, AHCCCS has also learned from its outreach experiences. Direct mailings have not worked well. Out of a total direct mailing of 116,476 costing almost $49,000, only 2,338 applications have been returned, for a return rate of 2.5 percent.

3.5 What other health programs are available to SCHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among SCHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between SCHIP and other programs (such as Medicaid, Maternal Child Health (MCH), WIC, and School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5

Type of coordination	Medicaid*	Maternal and child health	Other (specify) Premium Sharing Program	Other (specify)
Administration	√**		√	
Outreach	√	√	√	
Eligibility determination	√			
Service delivery	√			
Procurement				
Contracting	√			
Data collection	√			
Quality assurance	√			
Other (specify) Computer System* **	√			

* Note: This column is not applicable for States with a Medicaid SCHIP expansion program only.

** Note: Medicaid and SCHIP share administrative staff.

*** Note: AHCCCS has interfaced its automated systems to improve the eligibility process with Medicaid.

AHCCCS coordinates the KidsCare program with Title XIX, Arizona's six public initiatives mentioned later in this section, and public-private partnerships. Through coordination, children can be directed to the most appropriate program which fits each child's particular need.

Title XIX (Medicaid) Programs: Coordination and Consolidation

AHCCCS uses a dual application form for KidsCare and Title XIX so that a determination can be made for both programs. Each KidsCare applicant is first screened to determine if the child is potentially eligible for Title XIX coverage. If so, the application is transferred to DES for a final eligibility determination. AHCCCS has also interfaced its automated systems to improve the eligibility process.

The inter-agency referral process exists because KidsCare eligibility is performed by AHCCCS, while DES performs eligibility for families, children, and pregnant women. AHCCCS and DES strive to provide a seamless eligibility process where families may be offered health coverage for younger children who are often eligible for Title XIX coverage while older children may more readily qualify for KidsCare.

Efforts to Identify and Enroll Children through the Six Public Initiatives

In addition to Medicaid and counties, who also refer KidsCare applications to AHCCCS, KidsCare works closely with Arizona's six public initiatives noted below that help identify and enroll children in programs that serve children. This endeavor is very worthy because those children who do not qualify for KidsCare may find assistance via other programs, which are described below:

Outstationed Eligibility Workers

Arizona has outstationed eligibility workers at some of the 14 Federally Qualified Health Centers (FQHCs), in hospitals which serve a disproportionate number of low income persons, in health centers, and at five Arizona Department of Juvenile Corrections locations. At these outstationed sites, a person applying for Medicaid is assisted by an eligibility worker who will submit a completed application to the appropriate eligibility office. Many of these outstationed sites provide KidsCare applications and enrollment information. In addition, trainings were held and a manual was developed for FQHC employees on how to complete KidsCare applications.

Direct Health Services

Direct health services are provided by county public health departments based on a sliding-fee scale. County public health departments have provided KidsCare applications and enrollment information. In addition, the Pima County Health Department established a partnership with Carondelet Foundation to place a volunteer once a week in a WIC office. The volunteer assists with KidsCare applications.

Community Health Centers

Arizona has 27 community health centers, which offer a wide range of health care services based on a sliding fee scale. Community health centers provide primary care services, including care for acute and chronic illnesses, injuries, family planning and

prenatal care, emergency care and diagnostic services. The community health centers have been key community supporters of KidsCare. Trainings were held and a manual was developed for community health center employees on how to complete KidsCare applications.

Maternal and Child Health Block Grant

Maternal and Child Health Block Grant funds are administered by the Arizona Department of Health Services (ADHS). This department funds, monitors and evaluates a variety of statewide community-based programs, which provide outreach and assistance for enrollment in public health insurance programs. These programs include: Healthy Start, High Risk Prenatal Programs, Pregnancy and Breast Feeding Hotline, Children's Information Center, Reproductive Health, County Block Grant and Children's Rehabilitative Services. The AHCCCS Administration continues to work with our sister agency, ADHS, in providing applications and enrollment information to potential applicants.

Children's Rehabilitative Services

Funded by a Title V block grant, the ADHS/Children's Rehabilitative Services provide health care services to children with special health needs. Additionally, KidsCare and Medicaid eligible children receive services through CRS and AHCCCS reimburses ADHS with Medicaid funds for covered services provided by the program. A DES Family Assistance eligibility worker is located at each CRS site and field clinic to process KidsCare and Medicaid applications for public assistance programs.

Indian Health Services (IHS) and Tribal Entities

Arizona has three Offices of Indian Health Services, which are in Phoenix, Tucson and Navajo. Each area office has a designated service delivery area in which IHS Service Units and health centers provide health care services to Native Americans, including those who are AHCCCS members. These offices provide KidsCare applications and enrollment information.

In addition, Arizona has three urban Indian Health Centers, which have a unique relationship with IHS. Each Center receives an allotment from the IHS federal appropriation to provide health care services to Native Americans residing in Phoenix, Tucson and Flagstaff. These Centers also provide KidsCare applications and enrollment information.

Tribal governments have established health care programs for tribal members. In general, the majority of these services are behavioral health services and/or alcohol and substance abuse programs. The AHCCCS Native American Coordinator has worked closely with tribal governments on KidsCare outreach efforts.

In addition, the Gila River Indian Community has opted to contract for the delivery of

health care from the Phoenix Area IHS through the P.L. 93-638 contracting process. The Gila River Health Care Corporation is the tribal governing body which oversees the operation of the HuHuKam Memorial Hospital which is located on the Gila River reservation. The hospital provides primary health care services to tribal members and also operates an outpatient clinic on weekdays with scheduled appointments.

In addition, the Gila River Indian Community Department of Health, operates a Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) program through an intergovernmental agreement with AHCCCS. This tribal program ensures that children receive the services required in the KidsCare and Medicaid programs.

Coordination with Public-Private Partnerships

KidsCare has also benefited from coordination with public-private partnerships. The first, Baby Arizona, is a cooperative outreach initiative, which received a national Achievement Award, while the second partnership, the Premium Sharing Program assists the working poor and is entirely state-funded.

Baby Arizona

In December 1996, the Baby Arizona Project was one of five programs across the country to receive a national Achievement Award from Healthy Mothers, Healthy Babies. In 1994, a public-private partnership responded to a steady decline of mothers into early entry prenatal care by establishing Baby Arizona. The project, which is overseen by AHCCCS, uses a comprehensive approach to raise awareness about the importance of early prenatal care for Medicaid eligible mothers. A streamlined eligibility process is used to encourage women to apply for Medicaid.

In 1997, nearly 6,000 pregnant women called the ADHS hotline in response to the Baby Arizona campaign -- an increase of 25 percent over the last year. The project's marketing campaign was a success, with more than 60 percent of the callers requesting information about Baby Arizona. Approximately 68 percent of callers reported that they were in their first trimester or were not sure if they were pregnant. The hotline provided referrals to medical care and information about how to apply for AHCCCS through the Baby Arizona's streamlined eligibility process.

In addition to a successful prenatal outreach program, AHCCCS initiated a process to allow expectant mothers to apply for the Baby Arizona program at a physician's office or clinic. The program is now implemented statewide in Arizona's 15 counties with 350 physicians and certified nurse-midwives, or approximately 80 percent of all AHCCCS maternity care providers, participating in the streamlined Baby Arizona application process.

AHCCCS' experience with outreach in connection with its Baby Arizona program has prepared it to successfully conduct outreach for the KidsCare Program. Baby Arizona will also be a vehicle for outreach activities. Mothers who have children who are ineligible for Medicaid but who may be eligible for KidsCare will be provided an

application for the program.

Premium Sharing Demonstration Program

In 1996, the Arizona legislature authorized funding for a pilot Premium Sharing Program (PSP) for the working poor, funded entirely with state funds and minimal monthly premiums paid by the enrollee. The 1996 legislation was enacted to define the parameters of the program, which is limited to persons who reside in one of the four counties chosen for the pilot. The program began delivering services on February 1, 1998. Applicants for the program can have household income up to and including 200 percent of FPL; and persons who are chronically ill and who have been enrolled in the 100 percent state-funded MI/MN program for the previous 12 months, may have household income up to and including 400 percent of the FPL.

The PSP program is funded with $60 million in state funds, $20 million for each year of the pilot. The funding is capped; therefore, if the cost of the program exceeds the available funding, enrollment will be suspended. As members disenroll, applicants will be enrolled from a waiting list on a first-come, first-served basis.

Any family with a child who applies to PSP will be referred to KidsCare if it is believed that the child will be eligible for this program.

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your SCHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

_x_ Eligibility determination process:
_x_ Waiting period without health insurance (specify) (see below)
_x_ Information on current or previous health insurance gathered on application (specify) (see below)
__ Information verified with employer (specify)
__ Records match (specify
_x_ Other (specify) (random audits, please see 3.6.2)
__ Other (specify)

AHCCCS screens 100 percent of its KidsCare applications to determine if the child was covered by employer-sponsored insurance within the last six months.

___ Benefit package design:
___ Benefit limits (specify)
_x_ Cost-sharing (specify)

_x_ A $5 per non-emergency use of the emergency room

__ Other (specify)

N/A Other policies intended to avoid crowd-out (e.g., insurance reform):

___ Other (specify)
___ Other (specify)

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

First, AHCCCS screens 100 percent of all applications to determine if the child was covered by employer-sponsored insurance within the past month. As of October 1, 1999, 2.1 percent of total denials or 668 individuals were covered by group or other health insurance, and thus denied. This figure, which has remained relatively constant over the past year, does not include denials because children were eligible for Medicaid.

Second, AHCCCS has established a quality control program that is essential to monitoring crowd-out. Quality Control uses a sample of all KidsCare members to arrive at its monthly review total. During this reporting period, AHCCCS reviewed the eligibility decision at the time of eligibility. Quality Control reviews whether families had other insurance at the time of eligibility by following-up with families and other leads.

An applicant cannot have been covered under an employer's group health insurance plan or by private insurance within the last six months if the health insurance coverage was terminated for a reason other than involuntary loss of employment. This exclusion does not apply to newborns or to persons with group health insurance who resigned or have involuntarily lost their employment.